CalOMS Field Readiness
Region Meeting – November 17, 2003
Sacramento Meeting Notes

Attendees

The following table lists the participants in the CalOMS Field Readiness regional meeting of November 17, 2003.

County/Direct Provider/ADP	Representatives	
El Dorado	Alice Chopson	
Imperial	Andrea Kuhlen	Leticia Garcia
Napa	Marc Reisman	
Nevada	Carolyn Macdonald	Robert Erickson
Placer	Nellie Chenowith Cheryl Trenwith	Louie Cretaro
Plumas	Janice Stafford	
Sacramento	Sharon Beard	
San Benito	Marc Narasaki	
San Joaquin	George Feicht Jeff Brannon	Krzyztop Sidora
Solano	Del Royer	
Stanislaus	Mel Snow Connie Moreno-Peraza	Mark Morrison
Sutter-Yuba	Tom Metcalf	Karen Brown
Yolo	Rory Osborne	
Addiction Treatment Services	Birdie Klopf	
Aegis Medical Systems, Inc.	Valerie Mattoon Brian Atwell Bill Downing Lori Raff Chanchal Dola	Emily Scism Ruan Walters Monica Rios Dawn Fowler
Bridges Inc.	Ken Knutson	
CRC Health Corporation	Sharel Rogers	Kathleen Rodrigues
ETR Associates	Robert Raskin	
Healthy Babies Project, Inc.	Frances Goodson	Majeedah Rahman
NCADD	Stephanie Grajeda	Nikki Buckstead
Pharmatox, Inc.	Raymond Yuen Kathy Loughry	Michael Meredith
San Diego Health Alliance	Melissa Dykes	
The Living Center	Linda Wright	
Western Pacific Medical Group	Bill Wilson	
ADP	Claudio Mejia Sharon Dais Jon Meltzer Craig Chaffee Penny Tafoya	George Lembi Marjorie McKisson Susan King Sally Jew Tom Powers

CalOMS Field Readiness
Region Meeting – November 17, 2003
Sacramento Meeting Notes

MRC	Robin Madsen Chuck Czajkowski	Arielle Ocel Sharon Nelson

Opening and Introductions

Madsen Rayner Consulting (MRC) was hired by ADP for the Field Readiness portion of the CalOMS project. MRC staff facilitated the meeting, presented information on the Field Readiness project (deliverables and timeframes), led the discussion on top issues and concerns, and clarified any questions about the field readiness survey. ADP staff attended to present information on the CalOMS requirements, answer questions, and to listen to the issues and concerns from counties and direct providers.

Robin Madsen and Arielle Ocel noted the different venues for collecting feedback on field readiness from counties – survey, regional meetings, and follow-up conference calls.

Sharon Dais opened the meeting by giving background information to participants about CalOMS and highlighting the importance of counties and direct providers providing feedback to ADP via the field readiness surveys.

Field Readiness Presentation and Questions

The presentation has two focuses: 1) an overview of the CalOMS requirements and 2) the Field Readiness project deliverables and timeframes, including expectations on county and direct provider involvement.

George Lembi stated that ADP is currently at end of the requirements phase for CalOMS and beginning the field readiness assessment. Data collection for CalOMS begins in October, 2004.

CalOMS Requirements (Treatment)

ADP reviewed the four major points in time for data collection: Admission, Discharge, Post Admission, and Follow-up. ADP reviewed each of the data categories (i.e. PPG, CADDS, UCI, etc.) and the 9 month follow-up sampling methodology.

CalOMS model is for counties to work with treatment providers to collect CalOMS data. Counties will send data electronically to ADP. ADP, through CalOMS, will provide data back to counties as extracts and reports.

Question (Q), Answers (A) and Comments(C):

CalOMS Field Readiness
Region Meeting – November 17, 2003
Sacramento Meeting Notes

Q: Are the random samples being sent to the counties or to the individual providers in each county?
A: *The samples for follow-up will be sent to the counties.*

Q: How will counties identify which provider to send the follow-ups to?
A: *Counties can decide whether to perform the follow-ups at the county level or to have providers perform them. Provider ID will be part of the follow-up sampling report.*

Q: What about readmission – is another ASI required?
A: *CalOMS will follow the same protocol as CADDS currently does, so if a client is discharged and then admitted again, new admission data is required. ADP will explore whether there are any exceptions to this approach, regarding the collection of the ASI Lite. ADP will follow up on this.*

Q: Are counties required to use a computer-based ASI?
A: *Counties are required to send all data, including ASI data, to ADP in an electronic format.*

Q: Will clients be required to participate in follow-up in order to receive publicly funded treatment dollars?
A: *ADP will follow-up on this.*

Q: Who is providing the training to counties and providers?
A: *MRC will identify training needs via the readiness assessment. ADP allocated money and will contract to provide ASI and follow-up training. ADP estimates that ASI training will be needed for 50% of providers.*

Q: You state that there are "approximately 200" questions, but in the Data Elements Matrix you provided us, there are more than 300 data elements. What about the extra data elements?
A: *The approximately 200 questions represent non-duplicates at admission.*

Q: What about CADDS data?
A: *This will be collected via CalOMS. CADDS will no longer be used.*

CalOMS Field Readiness
Region Meeting – November 17, 2003
Sacramento Meeting Notes

Q: Someone said that it will take 10 hours per client to collect this data; is this correct?
A: *ADP will look into this. This estimate seems high. At a previous meeting, one county stated that they are using 10 hours as a per-client estimate to collect data for all time points.*

Q: Some states, such as Texas, adopted a central system and created a central ASI data collection system. Is California looking into this?
A: *We looked at it but this is not our plan because of California's relationship with the counties. If the counties choose to do that as a consortium, they can.*

Q: What about the counties that don't currently have an automated data collection system?
A: *There are sources of software available. Perhaps small counties can work together to create a consortium that uses one software system. The field readiness results will help ADP determine how prevalent this barrier is.*

Q: The survey seems to assume that you have an automated system. What do we do if we don't?
A: *Select the answer "None" for those questions.*

Q: Is this data collection a state requirement by regulation so counties can use that to leverage contracts?
A: *There will be language in NNA contracts.*

C: Counties need regulation detail from ADP. It is essential for counties to have this in order to get their vendors to comply with CalOMS and to get funding approved.

Q: Will CalOMS detect data errors before data is submitted?
A: *CalOMS will detect errors once data is submitted. See Data Elements Matrix for valid values. CalOMS will edit incoming data for errors. It is ADP's expectation that the same edits will be applied on the county side to minimize the number of errors.*

Q: What about a direct provider that operates in multiple counties? Will they have to submit from each county or can they submit via a central location?
A: *ADP direct contract providers may submit all counties together. For providers that contract with multiple counties, ADP will follow up on this.*

Q: We don't have enough people or money to do this. Can AOD work with DMH to collect questions that overlap and/or to standardize data?
A: *ADP will follow up on this.*

Q: Does the Unique Client Identifier (UCI) include the SIN?
A: *The SIN is not currently part of the UCI information. ADP will follow up on this.*

Q: Has ADP talked about the reduction of treatment necessary to fund the additional requirements? What is the threshold?
A: *No threshold has been defined at this point. The field readiness survies will collect county estimates on treatment impact*.

C: Counties are concerned about decreasing client service and increasing waiting lists.

C: The scale of CalOMS is too large. It is too much of an increase in data collection for counties and providers.

Q: Why should data collection take precedence over treatment?
A: *The data collection required for CalOMS is an investment that will benefit AOD treatment in the future. Results can be used to go to the legislature to maintain and increase funding. It is part of a quality improvement cycle.*

C: Is this the only possible way to approach this? The enormity of the CalOMS changes is the issue. Is there a more simple way to do this?

Field Readiness Project

MRC reviewed Field Readiness project, deliverables and timeframes. All counties and direct providers are being surveyed. After ADP's receipt of the surveys, MRC will have a follow-up conference call to confirm and clarify any survey questions. MRC will gather feedback, analyze and compile the data into individual field readiness assessment reports, as well as an overall report. In addition to the field readiness assessment reports, MRC will develop toolkit items to be provided to counties and direct providers. Additional toolkit ideas are needed from counties. Early in 2004 MRC will work with counties and direct providers to prepare individual county plans for the implementation of CalOMS.

Identify and Discuss top issues and concerns

The following issues were raised by meeting participants.

Q: At a previous meeting a parallel process for prevention was mentioned. What is happening with prevention?
A: *Prevention is about six months behind treatment. The information will be shared as it becomes available.*

CalOMS Field Readiness
Region Meeting – November 17, 2003
Sacramento Meeting Notes

Q: What if we're not ready in October 2004?
A: *We have asked the same questions of the Federal Government and do not know of any sanctions for not meeting the October 2004 deadline. It is very important for counties and direct providers to let us know when they could be ready in the field readiness survey. This is a follow-up item for ADP.*

Q: What about SACPA information? Is it embedded in CalOMS?
A: *No, you must still meet SACPA reporting requirements.*

Q: Why not link this data to SACPA so you don't have to enter it twice?
A: *This works for CADDS information because it is at the client level, but it wouldn't work for SACPA data because it isn't client level data.*

C: Counties are concerned that they will have multiple reporting points to ADP.

Q: The legal status valid values don't include SACPA.
A: *SACPA is under referral source.*

Q: What funding streams may we use to meet CalOMS requirements?
A: *Block grants (SAPT) can be used, but other funding sources have not been identified. ADP will address this. Jesse will create a funding fact sheet.*

Q: Will you include percentages for funding streams?
A: *ADP will follow up on this.*

Q: On page 8 of the requirements, it says DUI is "not part of Phase I". What is Phase II?
A: *We don't know.*

Q: On page 22 of the requirements it mentions, CBS. What is CBS?
A: *It is an acronym for a county coalition to develop a new AOD system*.

C: Timing concerns - Aging information systems are too costly to update. The new system (CBS) is not far enough along to meet CalOMS requirements.

Q: What are the specific outcomes that providers are going to be measured against for funding and performance? What are the consequences?
A: *ADP has not determined this yet. At some point, we will have to talk about targets and determine a baseline.*

Q: What questions on the ASI are truly relevant? There are so many questions.
A: *ASI questions interrelate and are needed to determine scores and factors, which can be used to show changes in client functioning over time.*

CalOMS Field Readiness
Region Meeting – November 17, 2003
Sacramento Meeting Notes

Q: Are there other instruments that can be used instead of the ASI?
A: *For CalOMS the ASI Lite CF is the required instrument.*

C: The amount of time that will be needed to work with clients to collect data is too much. Data entry is a challenge. The time needed for follow-up is too much.

Q: Can you list the 9 measurements required by the PPGs?

1. *alcohol use*
2. *all other drug use*
3. *employment status*
4. *criminal justice involvement*
5. *pregnant addicts and women with children*
6. *HIV transmission*
7. *tuberculosis transmission*
8. *co-occurring disorders*

SAMHSA is developing measures for living status (homelessness), social support, penetration rates, length of stay, and treatment competition.

ADP is currently clarifying this.

C: Why is the treatment provider held responsible for so many other factors (housing, employment, etc.)?

C: The validity of the ASI breaks down with dual diagnosis.
A: *For a small percentage of severe cases, ASI is not the best tool. For Axis II – less severe – ASI is still reliable.*

Q: How will providers be measured? How long are you retaining clients? Graduation rate? Recidivism rate? What is ADP looking for?
A: *ADP will follow up on this.*

Q: For narcotic treatment providers (NTP) you have a lot of long-term clients, how do you incorporate them into CalOMS?
A: *If already in admission when CalOMS starts, they will be reported in CADDS. If new, they will be reported in CalOMS. The provider/county will also have the* ***option*** *to convert current CADDS clients to CalOMS at startup.*

Q: Will provider performance data become public?
A: *ADP will follow up on this. Client records and any client identifying information will not be public record.*

C: One county feels that provider information will become public, so it can be reported to County Board of Supervisors, etc. This is a concern to providers.

C: At the county level, they will need to have and use provider performance data.
A: *For CalOMS at the State level, sampling will be done at the county level.*

CalOMS Field Readiness
Region Meeting – November 17, 2003
Sacramento Meeting Notes

Q: Are the PPG and CADDS data the only federal requirements?
A: *Yes, the rest are State requirements.*

Q: Is there a way to phase in the State requirements?
A: *We see the PPGs going in the direction of the state requirements. We want to be a step ahead.*

Q: Does CalOMS measure the number of client sessions or dosages received?
A: *No.*

Q: If a therapist does an ASI at admission then again at 6 months, won't there be a built-in bias towards improvement?
A: *There is no way to get around bias completely. Sampling may help. Inter-rater reliability is high with the ASI.*

Q: How is admission defined? Is there a window?
A: *Use the definition of admission from CADDS for intake. ADP is considering excluding detox clients from the ASI.*

C: Meeting participants listed the following as their biggest issues/concerns with CalOMS:

1. money
2. time
3. complexity
4. effect on treatment or client
5. staff resources
6. intake timeframe
7. training
8. data set size
9. prevention
10. standardized data collection procedures
11. provider evaluation concerns
12. prevention concerns

Q: What version of the ASI will be used for automation? Will providers be able to submit hardcopy?
A: *ASI Lite CF, 5th edition. It is up to the county as to whether they will accept hardcopy submissions from their providers. ADP requires electronic submission of data from counties and direct providers.*

Q: Has there been any client input in this process?
A: *No.*

C: The impact of CalOMS on treatment dollars may bias or impact the results.

C: For small contracted providers these requirements are overly complex and may prevent them from being able to provide services. This may reduce the number of providers in California.

C: Reduction of treatment dollars is a concern.

Q: Are the ASI elements going to be weighted for cultural differences?
A: *The ASI has been translated in to different languages. Overall there is reliability across cultures.*

Survey Overview

The survey is a self assessment instrument, with AOD treatment as its scope. One survey should be completed by each county and/or direct provider. MRC hopes that the survey will prompt counties to start thinking about and planning for the CalOMS implementation. Completed surveys are due to ADP on November 24, 2003 (one week after regional meeting).

Survey Discussion – Questions and Answers

None

Wrap-up

- Thanks to counties and providers for their participation and input.
- Surveys are due one week from today, November 17.
- MRC will distribute meeting notes back to participants.
- January 2004 – compiled field readiness data (survey and discussion results) will be shared at the CAADPAC quarterly meeting in January 2004.

Follow-up Items for ADP

- How are readmissions handled within CalOMS with regard to ASI collection?
- Will clients be required to participate in follow-up to receive publicly funded treatment?
- Counties requested that ADP provide them with updated regulations for CalOMS.
- What about a direct provider that operates in multiple counties? Will they have to submit from each county or can they submit via a central location?
- We don't have enough people or money to do this. Can AOD work with DMH to collect questions that overlap and/or standardize data?
- Should the Unique Client Identifier (UCI) information include the SIN?
- What are the consequences of counties not meeting the October 2004 deadline?
- What funding streams may we use to meet CalOMS requirements, including approved percentages? ADP will produce a funding fact sheet.

CalOMS Field Readiness
Region Meeting – November 17, 2003
Sacramento Meeting Notes

- How will providers be measured? How long are you retaining clients? Graduation rate? Recidivism rate? What is ADP looking for?
- Will provider performance data become public?
- How is admission defined? Is there a window? Use the definition of admission from CADDS for intake. ADP is considering excluding detox clients from the ASI.
- Someone said that it will take 10 hours per client to collect this data; is this correct? *ADP will look into this. This estimate seems high. At a previous meeting, one county stated that they are using 10 hours as a per-client estimate to collect data for all time points.*